Thrombocytes Test® Request Form, Flowcytometry Unit, Imam Zain Al-Abedeen A.S Hospital, Imam Hussain A.S Holy Shrine, Karbela, Iraq.

(Please, circule the appropriate choice)

Name: **Date of Birth**: / /

Gender: M F **Occupation:** **Address:**

Contact info (cell phone, email):

Clinical Data

Bleeding? Yes No **Bleeding Sites**? Mucocutaneous-GIT-CNS-Urinary-Joints-

Other(Please specify)

Severity of Bleeding **Mild** - rquired no treatment, only observasion
Moderate- required treatment, without platltes/RBC transfusion
Sever- life/sight threatening, required platelet/RBC transfsion

Other Clinical Data:Pyrexia-Anemia-Lymph Nodes-Spleen-Others( )

Laboratory Data

CBC: HB= g/dl, MCV= ,WBC= $*10^3$/uL, Platlet= $*10^3$/uL,MPV= fL

Blood Film:

Indication(s) for the thrombocyte Test®

1. Incidental thrombocytopenia at young age, abscent family history, ITP suspected
2. Thrombocytopenia and comorbidity that MAY cause thrombocytopenia or associated with ITP. e.g. NHL, chronic liver disease
3. Thrombocytopenia, drug-induced *vs.*ITP when ommiting medication not possible
4. Peripheral thrombocytopenia, hypersplenisim *vs.*ITP.
5. others (please specify)

Referring Physician

Physician Name: **Work Place**:

Signiture: **Date:**

Disclaimer: This testing was adopted and its performance characteristics were determined by the *Flowcytometry Laboratory at Imam Zain Al-Abedeen A.S Hospital*. It has not been cleared or approved by the *US Food and Drug Adminstration*. The manufacturer has labeled this kit for research use only. *It is extremely important to interpret all results based on clinical correlation and other laboratory parameters*.

www.izahospital.org
info@izahospital.org
07735025444 - 07812379795
07502620767 - 07602345876
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